DOT PHYSICAL QUESTIONNAIRE FORM

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOU.

1. **YES/NO** Have you been treated by any doctors within the last 2 years who were not your primary doctors? ***(If yes, you will need to bring medical records from those doctors)***
2. **YES /NO** Do you have an eye disorder/disease other than one that requires contacts or glasses? Ex: Glaucoma, cataracts, Macular degeneration etc.
   If yes list: ________________________________
   (If yes, you need clearance from your ophthalmologist)
3. **YES/NO** Are you diabetic? ***(If yes, you will need ophthalmology clearance within the last 2 years)***
   YES/NO Are you a diabetic on insulin? ***(If yes, you will need ophthalmology clearance within the last 2 years AND an Insulin-Treated Diabetes Mellitus Assessment Form from the insulin managing/prescribing physician)***
4. **YES/NO** Do you experience any of the following cardiovascular conditions: coronary artery disease, CABG, stent placement, CHF, heart murmur, irregular heartbeat, pacemaker, heart valve disorders, etc? ***If yes, explain:*** ____
   (If yes, you will need copies of most recent cardiology visit and stress test within the last 2 years. An EKG will be provided during your exam)
5. **YES/NO** Have you ever had a thoracic or abdominal aortic aneurysm? ***(If yes, you will need recent imaging report detailing size dimensions)***
6. **YES/NO** Do you have an amputated extremity? ***(If yes, you will need to have a FMCSA SPE Certificate before physical can be completed)***
7. **YES/NO** Do you wear glasses/contacts or hearing aids? ***(If yes, these will be required to complete exam)***
8. **YES/NO** Are you hard of hearing or experiencing hearing loss?
   If yes, explain: ____
   (If yes, audiometric testing will be completed during physical unless documentation within the last 6 months)
9. **YES/NO** Are you a smoker? ***(If yes, and over 35 you will need a PFT within the last 6 months or it will be done during the visit)***
10. **YES/NO** Have you been diagnosed with any pulmonary conditions such as any of the following: COPD, asthma, chronic cough, sarcoidosis, emphysema, etc? ***If yes, list:*** ______________________________
11. **YES/NO** Are you currently prescribed Coumadin or Warfin? ***(If yes, blood work will be done during exam)***

FOR OFFICE USE ONLY:

****ALWAYS ICD: Z00.00 CPT: 99383 & 81003****

--ANSWERS 1-7 REQUIRE ADDITON ITEMS FROM PT IF MARKED YES--

IF YES TO ANY QUESTIONS REFER TO CHART BELOW:

QUESTION 3: 36415 & 82948	**QUESTION 4:** 93000
QUESTION 8: 92551	**QUESTION 9:** 94010
QUESTION 10: 94010	**QUESTION 11:** 36415 & 85610

ADD 94010 FOR SUMTER TRANSPORT UNLESS OTHERWISE NOTED ON AUTH FORM

FASTER CARE PATIENT INFORMATION

1. Last Name____________________First Name______________________
2. Address:____
3. City, State, Zip:____
4. Home Phone:___________________Cell:_________________ Work: ____________
5. DOB:_______________Age:_______ 6. Weight:__________ Height:___________
7. Who is your regular doctor?____________________________________
8. What pharmacy do you want to use today?_________________________
This will be the pharmacy you use today. NO EXCEPTIONS
9. **Will you need a work or school note?** Circle: **WORK SCHOOL NONE**

10. What is your chief complaint today and when did it start:
________________________DOT PHYSICAL_____________________

11. List symptoms:____
____

12.Do you have any medical conditions? **Circle: YES or NO** If yes, you must list:
____
____
____

13. Are you allergic to any medications? **Circle: YES or NO** If yes, you must list
list:____
____
14. Do you take any medications? **Circle: YES or NO** If yes, you must list names of each: ____
____
____
15. Have you ever had any surgeries: **Circle: YES or NO** If yes, you must list:
____
____

16. Have you ever been hospitalized? **Circle: YES or NO** If yes, you must list reason:
____
____
____

17. Date of Last Tetanus:_______________________

If applicable, are your child's immunizations up to date? **YES or NO**

18. **Women:** Date of last period?___________________

Are you pregnant or nursing? **YES or NO**

Office Use: Time:
Ins:
Pre-auth:
Y or N

BP:	BP:
P:	P:
R:	R:
T:	T:
O2:	O2:

OFFICE USE, LEAVE BLANK.

19. **List hereditary medical conditions of people listed regardless if alive or deceased:**

Information unknown due to adoption [_]

Father: [_] alive [_] deceased: List hereditary conditions: ______________________________ **OR** No hereditary conditions[_]

Mother: [_] alive [_] deceased List hereditary conditions: ______________________________ **OR** No hereditary conditions[_]

Siblings: [_]alive [_] deceased List hereditary conditions: ______________________________ **OR** No hereditary conditions[_]

Children: [_] alive [_] deceased List hereditary conditions: ______________________________ **OR** No hereditary conditions[_]

20. Do you have someone to make medical decisions on your behalf should you become unable to make the decisions for yourself? **YES or NO** Name:____________________ Phone:______________________
Address:____

21. Use illegal drugs/substances? **YES or NO** If yes, what and how much? ______________

22. Do you drink alcohol? **YES or NO** If yes, please answer the following:

***How often did you drink alcohol this past year?

[ ]Never **[ ]Monthly or less** **[ ] 2-4 a month** **[ ]2-3 a week**

***How many drinks did you have on a typical day when you were drinking?

[ ]1-2 **[ ]3-4** **[ ]5-6** **[ ]7-8** **[ ]10 or more**

***How often did you have 6 or more drinks on one occasion in the past year?

[ ]Never **[ ]less than monthly** **[ ]Monthly** **[ ]Weekly** **[ ]Daily or almost daily**

23. Do you use Nicotine and/or Tobacco Procucts **Yes or No** If yes, which product

[ ]**Cigarettes** [ ]**Cigars** [ ]**Chewing Tobacco** [ ]**Dip/Snuff** [ ]**Hookah** [ ]**Patches** [ ]**Pipe** [ ]**Vape**

List if other:______________________________

24. Are you a current or former smoker? **Current Smoker** **Former Smoker (Skip to part B)**

A) If current smoker, answer the following questions

***How often do you smoke cigarettes? **[ ] Every day** **[ ] Some days, but not every day**

***How many cigarettes a day do you smoke? **[ ] 5 or less** **[ ] 6-10** **[ ] 11-20** **[ ] 21-30** **[ ] 31 or more**

***How soon after you wake up do you smoke your first cigarette?

[ ] within 5 min **[ ] 6-30 min** **[ ] 31-60 min** **[ ] +60 min**

*** Are you interested in quiting? **[ ] Ready to quit** **[ ] Thinking about quitting** **[ ] Not ready to quit**

B) If former smoker, answer the following question

***Are you a….

[ ]**Current non-smoker** [ ]**Ex-cigar smoker** [ ]**Ex-cigarette smoker** [ ]**Ex-pipe smoker** [ ]**Ex-user of moist powdered tobacco**

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICAL RECORD #

____

(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: ______________ First Name: ______________ Middle Initial: ___ Date of Birth: ______________ Age: ___

Street Address: ______________ City: ______________ State/Province: ______ Zip Code: ______

Driver's License Number: ______________ Issuing State/Province: ______________ Phone: ______

E-Mail *(optional)*: ______________ CLP/CDL Applicant/Holder*: ○ Yes ○ No

Driver ID Verified By**: ______________

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ○ Yes ○ No ○ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ○ **Yes** ○ **No** ○ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ○ **Yes** ○ **No** ○ **Not Sure**

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: ____________ First Name: ____________ DOB: ____________ Exam Date: ____________

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:

	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures/epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ **Yes** ○ **No** ○ **Not Sure**

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: ○ **Yes** ○ **No** ○ **Not Sure**

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: ____________ Date: ____________

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Last Name: ____________ First Name: ____________ DOB: ____________ Exam Date: ____________

TESTING

Pulse Rate: ______ Pulse rhythm regular: ○ Yes ○ No Height: ___ *feet* ___ *inches* Weight: ____ *pounds*

Blood Pressure	Systolic	Diastolic
Sitting		
Second reading *(optional)*		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.				

Other testing if indicated

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Vision

Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/_____	20/_____	Right Eye: _____ degrees
Left Eye:	20/_____	20/_____	Left Eye: _____ degrees
Both Eyes:	20/_____	20/_____	

	Yes	No
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	○	○
Monocular vision	○	○
Referred to ophthalmologist or optometrist?	○	○
Received documentation from ophthalmologist or optometrist?	○	○

Hearing

Standard: Must first perceive whispered voice at not less than 5 feet ***OR*** *average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).*

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☐ Neither

Whisper Test Results	Right Ear	Left Ear
Record distance *(in feet)* from driver at which a forced whispered voice can first be heard	________	________

OR

Audiometric Test Results

Right Ear: 500 Hz	Right Ear: 1000 Hz	Right Ear: 2000 Hz	Left Ear: 500 Hz	Left Ear: 1000 Hz	Left Ear: 2000 Hz
________	________	________	________	________	________

Average (right): ____________ Average (left): ____________

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	○	○	8. Abdomen	○	○
2. Skin	○	○	9. Genito-urinary system including hernias	○	○
3. Eyes	○	○	10. Back/spine	○	○
4. Ears	○	○	11. Extremities/joints	○	○
5. Mouth/throat	○	○	12. Neurological system including reflexes	○	○
6. Cardiovascular	○	○	13. Gait	○	○
7. Lungs/chest	○	○	14. Vascular system	○	○

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)

South Carolina Department of Motor Vehicles

Commercial Driver's License (CDL) Holders Medical Certification Requirements

DL-405A
(Rev. 3/12)

THIS ENTIRE FORM MUST BE COMPLETED BY THE APPLICANT
and must be completed in black or blue ink.

CURRENT LEGAL NAME (FIRST, MIDDLE, LAST, SUFFIX)

DATE OF BIRTH	SOCIAL SECURITY NUMBER	DRIVERS LICENSE NUMBER
/ /	- -	

CHECK THE APPROPRIATE BOX FOR THE TYPE OF OPERATION THAT APPLIES TO YOU
See Frequently Asked Questions (FAQ) for explanations

☐ **NON-EXCEPTED INTERSTATE** *(Required to have a DOT medical card/certificate)* **(NI)** Operates in interstate commerce and meets the qualification requirements under 49 CFR part 391

☐ **EXCEPTED INTERSTATE** *(See FAQ Sheet for list)* **(EI)** Operates in interstate commerce, but engages exclusively in transportation or operations excepted under 49 CFR 390.3(f), 391.2, 391.68 or 398.3

☐ **NON-EXCEPTED INTRASTATE** *(18-20 years of age and/or license with an "I" restriction)* **(NA)** Operates only in intrastate commerce and is subject to and meets State driver qualification requirements.

☐ **EXCEPTED INTRASTATE** *(Not applicable in South Carolina)* **(EA)** Operates only in intrastate commerce, but engages exclusively in transportation or operations excepted from State driver qualification requirements.

I certify under penalty of perjury that all statements above are true and correct.

SIGNATURE OF APPLICANT

DATE

If your CDL is current, you may submit this form along with any other documents that apply to you (Medical Examiner's Certificate, Federal Waiver, Skills Performance Evaluation) using one of the following options:

1) Mail this form and copies of medical documents to: **SCDMV - CDL Help Desk**
PO Box 1498
Blythewood, SC 29016-0028
2) Scan the documents and then email them to: CDLHelpDesk@scdmv.net
3) Fax this form and medical documents to the CDL Help Desk. Fax number is (803) 896-2676
4) Deliver this form and medical documents to your local SCDMV office. A list of office locations and hours can be found on our website www.scdmvonline.com

Please contact the CDL Help Desk at (803) 896-2673 if you have any questions regarding this form.